

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Carroll 21479
Village or City Westminster (No. 79)
2 FULL NAME Edward Ahern
STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 76
St.; Ward
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>1837</u> (Month) (Day) (Year)		
7 AGE <u>78</u> yrs. — mos. — ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Pauper</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Ireland</u>		
PARENTS	10 NAME OF FATHER <u>Unknown</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>	
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Dec 26, 1915 Edward Ahern
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1915, to Dec 23, 1915, that I last saw him alive on Dec 22, 1915, and that death occurred on the date stated above, at 8 p.m.
The CAUSE OF DEATH * was as follows:
Chronic valvular heart disease
(Duration) yrs. mos. ds.
Contributory
Secondary
(Duration) yrs. mos. ds.
(Signed) Henry M. Tapp, M. D.
Dec 26, 1915 (Address) Westminster Md.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State, yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL <u>Pauper, County Home</u>	DATE OF BURIAL <u>Dec 27th</u> , 1915
20 UNDERTAKER <u>H. B. Ankard & Son</u>	ADDRESS <u>Westminster</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

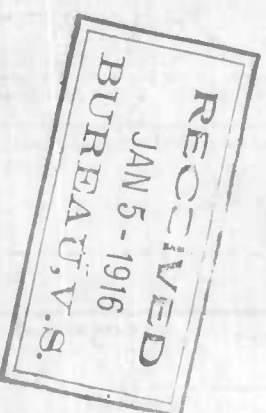
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

County Carroll 21480Village or City Oakland Mills (No. _____) St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 74

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George F. Arking

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH August 4, 1888
(Month) (Day) (Year)

7 AGE 27 yrs. 4 mos. 17 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER J. M. Arking

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Matilda Williams

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. H. O'Grady(Address) R. F. D. Sykesville

15 Filed Dec. 22, 1915 W. H. D. Swann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1915, to Dec. 21, 1915, that I last saw him alive on Dec. 15, 1915

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion following amputation of both legs.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory R. R. accident
(Secondary)

(Duration) 1 yrs. 3 mos. _____ ds.

(Signed) M. D. Thacker, M. D.
Dec. 21, 1915 (Address) Eldersburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harrisonville Md. Dec. 29, 1915

20 UNDERTAKER ADDRESS

Jas. R. Steen Sykesville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

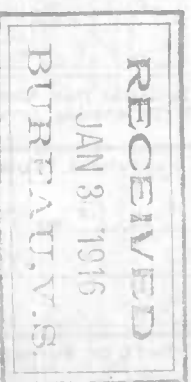
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name of organ: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 21481
County Carroll

Village or City Piney-brook (No. _____) St.; _____ Ward)

2 FULL NAME Howard W. Bankard

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 71

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH July 21, 1881
(Month) (Day) (Year)

7 AGE 34 yrs. 5 mos. 6 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll Co Md

10 NAME OF FATHER Jacob Bankard

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Bankard

13 BIRTHPLACE OF MOTHER (State or country) Carroll Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Annie Bankard

#3 Rd Leetheston Pa
(Address)

15 Filed Dec 28th, 1915, James G. Billmeyer
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 27th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1915, to Dec 27, 1915.

that I last saw him alive on Dec 27, 1915.

and that death occurred on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory Chronic
Secondary Nephritis

(Duration) 10 yrs. _____ mos. _____ ds.

(Signed) Luther Kemp, M. D.

Dec 28, 1915 (Address) Uniontown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baust Church Dec 30, 1915

20 UNDERTAKER ADDRESS

C.D. Fuss & Son Tangtown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day-laborer*, *Farm-laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 4 1916

BUREAU, U. S.

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1 PLACE OF DEATH
County Carroll 21482
Village or City Green Valley (No. 10) St. _____ Ward _____
2 FULL NAME Bula May Bish

STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 72

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec 25, 1894
(Month) (Day) (Year)

7 AGE 20 yrs. 11 mos. 29 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House maid
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Horatio L. T. Bish

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia O. Fraser

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Horatio L. T. Bish
(Address) Westminster Md. AD 17

15 Filed Dec. 26, 1915 John H. Hunt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 24th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1915 to Dec 24th, 1915, that I last saw her alive on Dec 23rd, 1915, and that death occurred on the date stated above, at 6:30 a. m. The CAUSE OF DEATH* was as follows:
Diabetes
Insural
(Duration) 4 yrs. _____ mos. _____ ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. R. Fleagle, M. D.
Dec 24th, 1915 (Address) Hammer Pa

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Silver Run DATE OF BURIAL Dec 27, 1915

20 UNDERTAKER Edw. F. Graft ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS—state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U. S.

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1 PLACE OF DEATH

21483

County Carroll Co.Village or City near Soneytown (No. 120)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Clay Bishop

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Dec 11, 1853
(Month) (Day) (Year)

7 AGE

62 yrs. no mos. 19 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll Co.

PARENTS

10 NAME OF FATHER

Henry Bishop

11 BIRTHPLACE OF FATHER (State or country)

Carroll Co

12 MAIDEN NAME OF MOTHER

Mary Wheeler

13 BIRTHPLACE OF MOTHER (State or country)

Fredericks Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Bishop

(Address)

Soneytown Md

15

Filed Jan 1st 1916 W.B. Hagan REGISTRAR
LocalSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 70

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 30, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 29th 1915 to Dec 30th 1915
that I last saw him alive on Dec 30th 1915and that death occurred on the date stated above, at 3:20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Contributory Diabetic Coma
Secondary (Duration) 2 yrs. no mos. no ds.
(Signed) Chandoe M. Benner, M. D.
Dec 31st 1915 (Address) Soneytown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residences _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

SoneytownJan 1, 1916

20 UNDERTAKER

ADDRESS

C. O. Fuss & Son Soneytown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

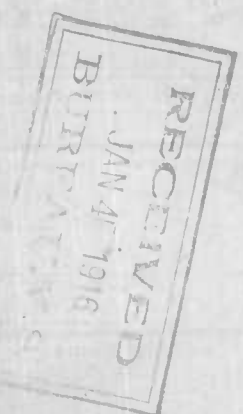
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Carroll

21484

69

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

74

Village or City

Sykesville

(No.

Springfield Hospital

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Bradley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

November 12th, 1890

7 AGE

25 yrs. 1 mos. 4 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. City. Md.

PARENTS

10 NAME OF FATHER

Walter B. Bradley

11 BIRTHPLACE OF FATHER

Scotland

12 MOTHER NAME OF MOTHER

Grace Starke

13 BIRTHPLACE OF MOTHER

Wash. D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Springfield Hosp. Records

(Address)

Sykesville. Md.

15

Filed

Dec. 19, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

December 16th, 1915

17

I HEREBY CERTIFY, That I attended deceased from

December 9th, 1915, to December 16th, 1915,that I last saw him alive on December 16th, 1915,

and that death occurred on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH * was as follows:

Epilepsy

Contributory

Status Epilepticus

(Signed)

John Norfolk Monroe, M. D.

Dec. 17th, 1915 (Address) P. O. Box 4, Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. 13 ds.

In the

State, 25 yrs. 1 mos. 4 ds.

Where was disease contracted,

Balto. Md.

If not at place of death?

Former or

usual residence Balto. Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sykesville Md.

Dec. 19, 1915

20 UNDERTAKER

ADDRESS

Jas R. Weer

Sykesville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *(tricycle)*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Reacher wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 3 1916
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

21485

County

Carroll

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 81

Village or City

Union Bridge

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lina H. Clary

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

6 - 8, 1860

(Month) (Day) (Year)

7 AGE

55 yrs. 5 mos. 17 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Frederick Co Md

10 NAME OF FATHER

Jesse J. Clary

11 BIRTHPLACE OF FATHER

Frederick Co Md

12 MAIDEN NAME OF MOTHER

Susana Dolderar

13 BIRTHPLACE OF MOTHER

Frederick Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dora Clary

(Address)

Union Bridge Md

15

Filed

Dec 7, 1915

Lester D. Repp Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12 - 5, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12 - 5, 1915, to 12 - 5, 1915,

that I last saw her alive on the time 1915,

and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH * was as follows:

Death was sudden caused by paralysis of heart

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

Dr. Jas. Watt

M. D.

12 - 7, 1915 (Address) Union Bridge Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. View Cemetery

12 - 8, 1915

20 UNDERTAKER

ADDRESS

Frank J. Shriner

Union Bridge Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

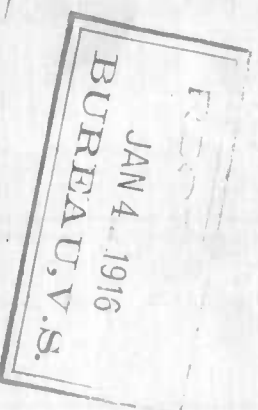
[Approved by U. S. Census and American Public Health Association.]

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ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dibility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Carroll</u>		21486		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Winfield</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>78</u>	
2 FULL NAME <u>David Cover</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>June - 30th</u> , 18 <u>67</u> (Month) (Day) (Year)					
7 AGE <u>68</u> yrs. <u>5</u> mos. <u>15</u> ds. It LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer (retired 2 yrs.)</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Josiah Cover</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Susannah Engle</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Laura J. Cover</u> (Address) <u>Winfield, Md.</u>					
15 Filed <u>Dec. 17</u> , 191 <u>5</u> <u>Jacob Farness</u> <u>Qual</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Dec 18</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>No attendance</u> 191 <u>5</u> to _____, 191 <u>5</u> that I last saw him alive on <u>Dec 18</u> , 191 <u>5</u> and that death occurred on the date stated above, at <u>4:30 P. m.</u> The CAUSE OF DEATH* was as follows: <u>apoplexy</u> <u>instantaneous</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Senile Degeneration</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>E. D. Brook</u> , M. D. <u>Dec 16</u> , 191 <u>5</u> (Address) <u>Woodbine</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Taylorville M. E. Cemetery</u>				DATE OF BURIAL <u>Dec - 18th</u> , 191 <u>5</u>	
20 UNDERTAKER <u>L. M. Matt</u>				ADDRESS <u>Winfield, Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

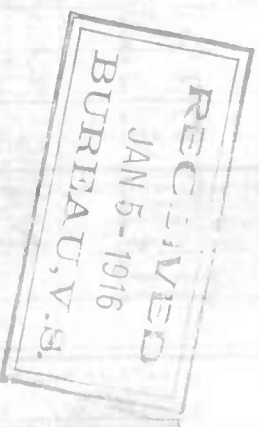
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

21487

County CarrollVillage or City near Dornings (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 78

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Doss

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Unknown, 1 _____
(Month) (Day) (Year)

7 AGE about 75 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Timber
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Harn(Address) R. 2, New Windsor, Md.

15 Filed Dec. 22, 1915 Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Accidental death

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Accidently burned to death by house falling down.
No inquest deemed necessary.
The deceased (Duration) lived alone

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Jacob Farver, J. P. Acting Coroner, M. D.
, 191____ (Address) _____

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. James M. E. Cemetery DATE OF BURIAL Dec. 23, 1915

20 UNDERTAKER C. M. Walz ADDRESS Winfield, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

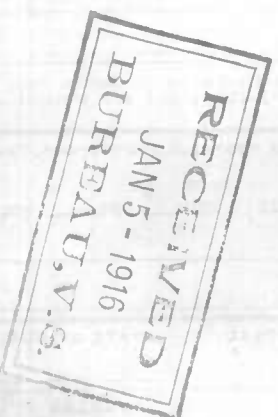
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Harris

21488

43

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

53

Village or City

Cannalton

(No.

St.:

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary A. Evans

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

June

23

1865

(Month)

(Day)

(Year)

7 AGE

50

yrs.

5

mos.

29

ds.

OR LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Own home

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John L. Leather

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary A. Lehnert

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. G. Griston

(Address)

Hampstead Md

15

Filed

Dec 23, 1915

M. J. Linsler

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12

22

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept. 27,

1915,

to Dec. 22,

1915.

that I last saw her alive on Dec. 22, 1915

and that death occurred on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma, mammary

(Duration) — yrs. 6 mos. — ds.

Contributory
Secondary

Metastatic Carc. of Liver

(Duration) — yrs. 3 mos. — ds.

(Signed)

Edgar M. Bush

, M. D.

12/22/15

(Address)

Hampstead, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

____ yrs. ____ mos. ____ ds.

In the

State

____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Church

Dec 24, 1915

20 UNDERTAKER

ADDRESS

A. V. Griston & Son Hampstead Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Carroll 21489
State of Maryland
CERTIFICATE OF DEATH

Registered No. 72

Village or City Myers District (No. 154) St.; Ward) 172

2 FULL NAME Sarah A. Feeser

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH January 3, 1833
(Month) (Day) (Year)

7 AGE 82 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. ? OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Chas. Weibling

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

11

13 BIRTHPLACE OF MOTHER (State or country)

11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Horatia S. J. Bish

(Address) Washington, M. D. R. 9

15 Dec 9, 1915 John W. Humbert
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 7th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 25th, 1915 to Dec 8th, 1915

that I last saw her alive on Dec 6th, 1915

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

General weakness
Primary fracture of
left hip joint (Duration) yrs. 1 1/2 mos. ds.

Contributory (Secondary)

Fracture of left (Duration) yrs. mos. ds.

(Signed) G. R. Fleagle, M. D.
Dec 8th, 1915 (Address) Hammer Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Silver Run Cemetery DATE OF BURIAL Dec. 10, 1915

20 UNDERTAKER E. M. Kaubenstein ADDRESS Rt. 1, Hamers, Pa.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the diseases CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll

21490

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 73Village or City Carrollton (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edith Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Feb 17, 1877
(Month) (Day) (Year)

7 AGE 38 yrs. 10 mos. 6 ds. IF LESS than
1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER don't know

11 BIRTHPLACE OF FATHER (State or country) don't know

12 MAIDEN NAME OF MOTHER Amanda Taylor

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David F. Green(Address) Carrollton

15 Filed Dec 24, 1915 E. L. Skinner
Deputy Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1915, to Dec 20, 1915

that I last saw him alive on Dec 20, 1915

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thos. J. Coonan, M. D.
Dec 24, 1915 (Address) Westish - Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Carrollton DATE OF BURIAL Dec 26, 1915

20 UNDERTAKER Frank C. Sharrer ADDRESS Westish - Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

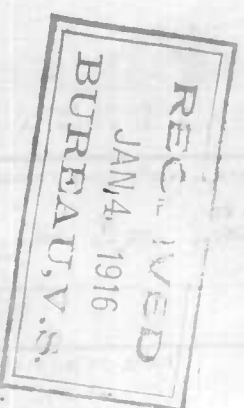
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-ferential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll 21491Village or City Hockinsville (No. 64)

2 FULL NAME

Gabriel HammerSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 77

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 4 25 1825
(Month) (Day) (Year)

7 AGE 90 8 1
yrs. mos. ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. J. Tipton(Address) Hampstead Md15 12/22/15 1915 Wm. J. O'Leary

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 26 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1913 to Dec 25 1915

that I last saw him alive on Dec 25 1915

and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Gen. Senility with Arterio-Sclerosis

(Duration) 2 yrs. — mos. — ds.

Contributory Cerebral Degeneration
Secondary

(Duration) 3 yrs. — mos. — ds.

(Signed) Edgar M. Bush M. D.

12/26/15 1915 (Address) Hampstead Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Leiste's Church DATE OF BURIAL 12-28, 1915

20 UNDERTAKER C. J. Tipton ADDRESS Hampstead Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

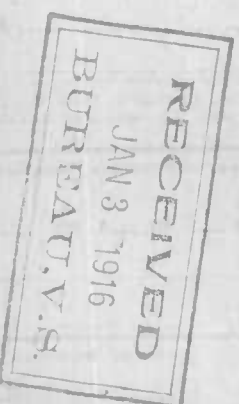
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

21492

Village or City

Alesia

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 75

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Geo L Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

10 / 1 / 1839
(Month) (Day) (Year)

7 AGE

76 yrs. 2 mos. 16 ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Alesia Ind

10 NAME OF FATHER

Peter Henry

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)Alesia Ind.

12 MAIDEN NAME OF MOTHER

Elizabeth Luckalange13 BIRTHPLACE OF MOTHER
(State or country)Pot Rumer

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary S. Henry

(Address)

Alesia Ind.

15

Filed 12/17, 1915J. P. Baltozer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12 / 16 / 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

February, 1915, to December 15, 1915,that I last saw him alive on December 15, 1915,and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH * was as follows:

Old Age(Duration) yrs. 10 mos. ds.Contributory
SecondaryLobar Pneumonia (Duration) yrs. 5 mos. ds.(Signed) E. R. Allis, M. D.12/17, 1915 (Address) Shen Rock Pa

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shen York Co Pa 12/19, 1915

20 UNDERTAKER

ADDRESS

W L Bergman ManchesterInd.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

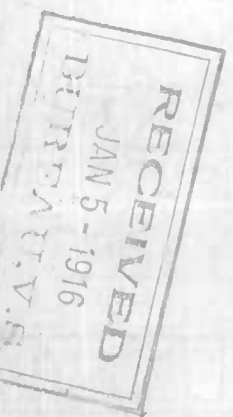
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Mill engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis,*

gcs, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, STRUCK, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinforced wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <u>Carroll</u>		21493		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>New Windsor</u>		(No. <u>5</u>)	Registration Dist. No. <u>80</u>		
2 FULL NAME <u>Still-born</u>		St. <u>Hoff</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Unknown</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>December 19th</u> , 191 <u>5</u> (Month) (Day) (Year)		7 AGE ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>New Windsor, Md</u>					
PARENTS	10 NAME OF FATHER <u>Samuel W. Hoff</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Emma C. Styermer</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel W. Hoff</u> (Address) <u>New Windsor</u>					
15 Filed <u>Dec 27</u> , 191 <u>5</u> <u>J. Edward Chest</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>December 19th</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still-born</u>					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u>Phelley Gentry</u> , M. D. <u>Dec 20th</u> , 191 <u>5</u> (Address) <u>New Windsor</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u>				DATE OF BURIAL <u>Dec 19th</u> , 191 <u>5</u>	
20 UNDERTAKER <u>None</u>				ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll 21494STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (No. Springfield State Hospital Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Martha J. Hollis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH November Unk. 1842
(Month) (Day) (Year)

7 AGE 73 yrs. Unk. mos. Unk. ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Delaware

PARENTS
10 NAME OF FATHER Chas. Hollis
11 BIRTHPLACE OF FATHER (State or country) Delaware
12 MAIDEN NAME OF MOTHER Lavinia Stafford
13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hosp. Records
(Address) S. S. Hosp., Sykesville, Md.

15 Filed Dec. 30, 1915 W. H. L. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1915, to December 30, 1915, that I last saw her alive on December 29, 1915, and that death occurred on the date stated above, at 2⁰⁰ m. The CAUSE OF DEATH * was as follows:

Arterio-Sclerosis & Chronic Interstitial Nephritis
(Duration) 2 yrs. 5 mos. 7 ds.

Contributory
Secondary

(Signed) John L. Wilkerson, M. D.
Dec. 30, 1915 (Address) S. S. Hosp., Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 yrs. 5 mos. 7 ds. In the Since a child State, yrs. mos. ds.
Where was disease contracted, If not at place of death?

Former or usual residence Preston, Pawling Co.

19 PLACE OF BURIAL OR REMOVAL Preston, Md. DATE OF BURIAL Dec. 30, 1915

20 UNDERTAKER Geo. R. Nees ADDRESS Sykesville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dentist," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"); *unqualified*, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JAN 3. 1916
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21495Village or City Uniontown (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 71

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Cyrus Jacob Hull

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)
----------------------	---------------------------------	--

6 DATE OF BIRTH
Jan. 18, 1840
(Month) (Day) (Year)7 AGE
75 yrs. 11 mos. 3 ds.
If LESS than 1 day, ____ hrs. OR ____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE
(State or country) Carroll Co10 NAME OF FATHER David Hull11 BIRTHPLACE OF FATHER
(State or country) Carroll Co12 MAIDEN NAME OF MOTHER Sarah Little13 BIRTHPLACE OF MOTHER
(State or country) Carroll Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Muller Snider(Address) Uniontown Md15 Filed Dec. 21st, 1915, Jesse H. Billmeyer
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 21st, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec. 20th, 1915, to Dec. 21st, 1915,that I last saw him alive on Dec. 20th, 1915,and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH * was as follows:

Epithelioma of face(Duration) 3 yrs. ____ mos. ____ ds.Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Luther Kemp, M. D.
Dec. 21st, 1915 (Address) Uniontown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residences

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pipe Creek Cemetery, Dec. 22nd, 1915

20 UNDERTAKER

ADDRESS

Hobanhard & son, Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

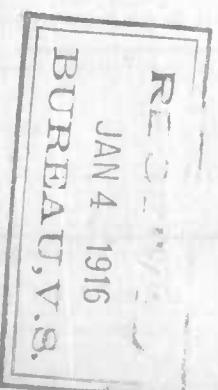
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *Name*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Brecher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21525STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 76Village or City Westminster (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John C. Leffert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept 7, 1866
(Month) (Day) (Year)

7 AGE 59 yrs. 3 mos. 2 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Cigar Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Henry Leffert

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (State or country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Deanton Warehouse(Address) Westminster

15 Filed Dec -10th, 1915 E. H. Shriver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1914, to Dec 9th, 1915;

that I last saw him alive on Dec 9th, 1915;and that death occurred on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia and
Contributory Pulmonary Hemorrhage
Causing Death
No other cause (Duration) ____ yrs. ____ mos. ____ ds.

Contributory Pulmonary Hemorrhage
Secondary (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John J. Stewart, M. D.
Dec 10th, 1915 (Address) Westminster

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Westminster DATE OF BURIAL Dec 11, 1915

20 UNDERTAKER Frank C. Shriver ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

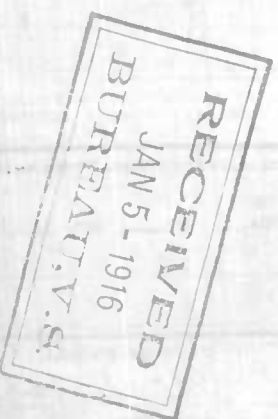
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

21496

County

Carroll

Village or City

near Dennings

(No. _____)

St.; Ward)

Registration Dist. No.

80

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Martha E. Lovell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

January 28, 1853
(Month) (Day) (Year)

7 AGE

62 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Reuben Haines

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Lambert

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Lovell

(Address)

P. O. #1, New Windsor, Md.

15

Filed

Dec 7, 1915

J. Edward West

Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 6, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 5, 1915, to Dec 5, 1915,

that I last saw him alive on Dec 5, 1915,

and that death occurred on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 4 yrs. mos. ds.

Contributory

Secondary

General Paralysis (Duration) 4 yrs. mos. 4 ds.

(Signed) L. E. Shipley, M. D.

Dec 7, 1915 (Address) Woodbine, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. James M. E. Cemetery Dec 8, 1915

20 UNDERTAKER

ADDRESS

C. M. Wally Minfield

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

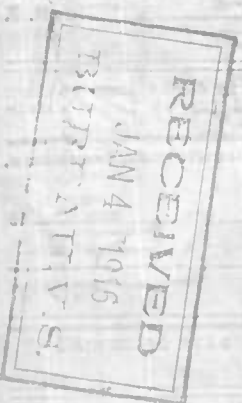
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll

21497

1232

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 56Village or City Westminster (No. 68)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Michael McCann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Feb 17, 1833
(Month) (Day) (Year)

7 AGE 82 yrs. 10 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER don't know

11 BIRTHPLACE OF FATHER (State or country) don't know

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (State or country) don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaiah Brooks(Address) Westminster

15 Filed Dec 20, 1915 C. W. Shriver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1915, to Dec 18, 1915.

that I last saw him alive on Dec 18, 1915and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Susane

(Duration) yrs. mos. ds.

Contributory same
Secondary

(Duration) yrs. mos. ds.

(Signed) Jas. H. K. [illegible]
[illegible], 1915 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westminster DATE OF BURIAL Dec 21, 1915

20 UNDERTAKER Frank C. Shaver ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

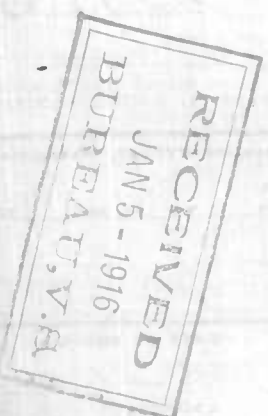
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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Carroll

21498

(120)

Village or City

Manchester

No.

St.;

Ward)

2 FULL NAME

Cornelius Miller

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

7-5

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male white

4-COLOR OR RACE

5 SINGLE,
MARRIED, married
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

May 21, 1843
(Month) (Day) (Year)

7 AGE

72 yrs. 7 mos. 9 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Stone Cutter

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Adams Co. Pa

10 NAME OF FATHER

Isaac Miller

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Susan Hershey

13 BIRTHPLACE OF MOTHER

(State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. H. Miller

(Address)

Manchester Md

15

Filed

12/31, 1915 J. P. Baltoga

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

6 DATE OF DEATH

Dec 31, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Dec 19, 1915, to Dec 31, 1915,

that I last saw him alive on Dec 31, 1915,

and that death occurred on the date stated above, at 79 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic NephritisContributory
Secondary

Myocarditis

(Signed)

William R. S. Dummer, M. D.

Dec 31, 1915 (Address) Manchester, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

In the

of death yrs. mos. ds.

State, yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Manchester Md

1/2, 1916

20 UNDERTAKER

ADDRESS

W. F. Reymann Manchester

Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

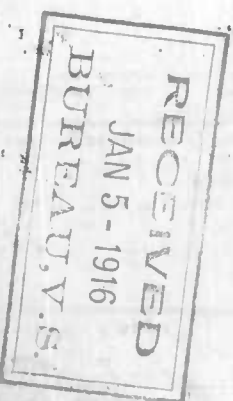
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Tail engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asplenia," "Anemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con- genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspond-ence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

21499

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Carroll

Registration Dist. No.

74

Village or City

Sykesville, Md. (No. Springfield State Hospital, Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Susie Moresbach

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Unknown, 1881
(Month) (Day) (Year)

7 AGE

34 yrs. Unknown mos. Unknown ds.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Hungary

PARENTS

10 NAME OF FATHER

Joseph Berwanger

11 BIRTHPLACE OF FATHER
(State or country)

Hungary

12 MAIDEN NAME OF MOTHER

Julia Reck

13 BIRTHPLACE OF MOTHER
(State or country)

Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address) S. S. Hosp., Sykesville, Md.

15

Filed

Dec. 27, 1915

Notary Public

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 21, 1915, to December 25, 1915,

that I last saw her alive on December 25, 1915,

and that death occurred on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH * was as follows:

Paralysis

over 1 yrs. 6 mos. Unknown ds.
(Duration)

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) John L. Withers, M. D.

Dec. 26, 1915 (Address) S. S. Hosp., Sykesville, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 6 mos. 4 ds. In the State, 12 yrs. Unknown mos. ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence 1434 Reynolds St., Balto., Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brooklyn A. C. C. Md. Dec 28, 1915

20 UNDERTAKER

ADDRESS

Eas. T. Weer Sykesville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

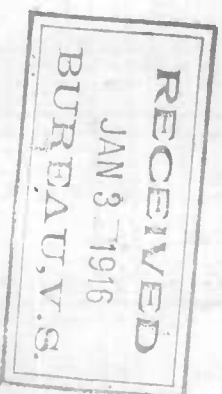
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

21500

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 76Village or City Fryzelburg (No. 119)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME David E. Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept 8, 1838
(Month) (Day) (Year)

7 AGE 77 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll

10 NAME OF FATHER Daniel Myers

11 BIRTHPLACE OF FATHER (State or country) Carroll

12 MAIDEN NAME OF MOTHER Mary Gauger

13 BIRTHPLACE OF MOTHER (State or country) Carroll

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Myer(Address) Westminster Md

15 Filed Dec 26, 1915 E. W. Shiner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 25th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1915, to Dec. 25th, 1915,

that I last saw him alive on Dec. 23rd, 1915,

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Emphysema of foot.

Contributory Nephritis (acute)
Secondary

(Duration) yrs. mos. ds. 6
(Signed) Chas. R. Fouts, M. D.
Dec. 26, 1915 (Address) Westminster Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baust cemetery DATE OF BURIAL Dec 28, 1915

20 UNDERTAKER H. Bankard & Son ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Art engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 5 - 1916
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

21501

County CarrollVillage or City Near Taneytown (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 70

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Harry E. Ohler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH

Aug 3, 1896
(Month) (Day) (Year)

7 AGE

19 yrs. 4 mos. 5 ds. 1 day, 5 hrs. 5 min. ?
OR LESS than

8 OCCUPATION

(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Carroll Co Ind

PARENTS

10 NAME OF FATHER

Milton. Ohler11 BIRTHPLACE OF FATHER
(State or country)Frederick Co Ind

12 MAIDEN NAME OF MOTHER

Sarah E. Clute13 BIRTHPLACE OF MOTHER
(State or country)Carroll Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Milton. Ohler

(Address)

Taneytown Ind

15

Filed Dec 9th, 1915 W. B. Hagan
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 8th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24th, 1915, to Dec 8th, 1915
that I last saw him alive on Dec 8th, 1915

and that death occurred on the date stated above, at 2 9 a.m.
The CAUSE OF DEATH* was as follows:

Typhoid Fever
Walking type
(Duration) 14 ds.

Contributory
Secondary

(Signed) Chandos M. Benner, M. D.
Dec 9th, 1915 (Address) Taneytown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 19 yrs. 4 mos. 5 ds. In the State 19 yrs. 4 mos. 5 ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taneytown IndDec. 10, 1915

20 UNDERTAKER

ADDRESS

C. O. Foss & Son Taneytown
Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

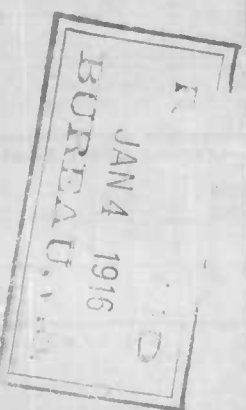
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

21502

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty Carroll mdRegistered No. 42Village or City Carroll Co (No. _____)

St; _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John A Orndorff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH

May 5, 1885
(Month) (Day) (Year)

7 AGE

80 yrs. 7 mos. 7 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE (State or country)

Penn

PARENTS

10 NAME OF FATHER

John Orndorff

11 BIRTHPLACE OF FATHER (State or country)

Penn

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E Orndorff(Address) Westminster

15

Filed Dec 13, 1915John W. H. H. H.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 12, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 12, 1915, to Dec 12, 1915.that I last saw him alive on Dec 12, 1915.and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Epistaxis of head and face(Duration) 3 yrs. ____ mos. ____ ds.

Contributory (Secondary)

uremia(Duration) ____ yrs. ____ mos. 1 ds.

(Signed)

H. W. Kohler

, M. D.

Dec 14, 1915 (Address) Littlestown Pa

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Littlestown Pa

DATE OF BURIAL

Dec 14, 1915

20 UNDERTAKER

J. H. Eline

ADDRESS

Littlestown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Pu

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

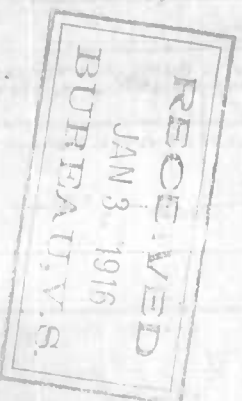
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

21503

County CarrollVillage or City Berret (No. _____, _____ St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 83

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME _____ Raynile

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Dec. 6, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) md.

PARENTS
10 NAME OF FATHER Roland Paynile
11 BIRTHPLACE OF FATHER (State or country) md.
12 MAIDEN NAME OF MOTHER Carrie Shipley
13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roland Paynile
(Address) R. F. D. 2 Sykesville

15 Filed Dec 7, 1915 M. Glennan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Transverse presentation
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Morris, M. D.

Dec 6, 1915 (Address) Eldersburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brandenburg Cemetery Dec 7, 1915

20 UNDERTAKER ADDRESS

C. M. Waltz & Gearhart Windfield Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

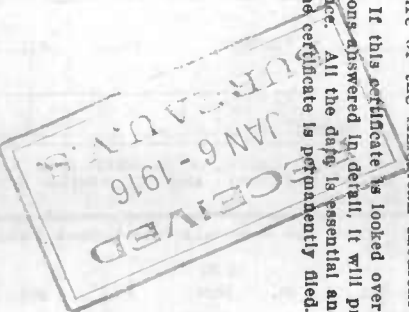
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not actually employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Triaemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Carroll</u> 21504			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Union Bridge</u> (No. <u>40</u>)			Registration Dist. No. <u>81</u>		
2 FULL NAME <u>Mary Missouri Rinehart</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED OR DIVORCED <u>widowed</u> (Write the word)			
6 DATE OF BIRTH <u>6 - 2 - 1850</u> (Month) (Day) (Year)					
7 AGE <u>65</u> yrs. <u>6</u> mos. <u>25</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Fredricks Co, Md.</u>					
PARENTS	10 NAME OF FATHER <u>Reuben Devilbiss</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Fredricks Co Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Feterling</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll Co Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>David Rinehart</u> (Address) <u>Union Bridge Md.</u>					
15 Filed <u>12/29</u> , 191 <u>5</u> <u>L. Leslie</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Dec 28</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 25</u> , 191 <u>5</u> , to <u>Dec 28</u> , 191 <u>5</u> , that I last saw h. or alive on <u>Dec 28</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>12:5</u> a.m. The CAUSE OF DEATH * was as follows: <u>Carcinoma (Liver)</u>					
Contributory <u>Stomach</u> (Duration) ____ yrs. ____ mos. ____ ds. (abdominal) (Signed) <u>J. H. Legg</u> , M. D. <u>Dec 29</u> , 191 <u>5</u> (Address) <u>Union Bridge Md</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from violent CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Mountain View Cem.</u>					DATE OF BURIAL <u>12-30</u> , 191 <u>5</u>
20 UNDERTAKER <u>Frank J. Shriver</u>					ADDRESS <u>Union Bridge Md.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REC
JAN 4. 1916
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll 21505STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (No. Springfield St. Hospital Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ida Ristiski

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown Unknown 1945
(Month) (Day) (Year)

7 AGE 70 yrs. Unknown mos. Unknown ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) Unknown
12 M maiden NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) S. S. Hosp., Sykesville, Md.

15 Filed Dec. 26, 1915 North REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1915, to Sept. 26, 1915,

that I last saw her alive on Dec. 25, 1915,

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH * was as follows:

Arterio-sclerosis & Chronic
Intermittent Nephritis
(Duration) ____ yrs. 3 mos. 9 ds.

Contributory
Secondary

(Signed) John L. Wethered, M. D.
Dec. 26, 1915 (Address) S. S. Hosp., Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. 3 mos. 9 ds. In the State, Unknown yrs. ____ mos. ____ ds.
Where was dissection conducted, If not at place of death?

Former or usual residence 2004 Fountain St. Balto. Md.

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL Dec. 28, 1915

20 UNDERTAKER Geo. R. Nease ADDRESS Sykesville

If more blanks are needed, address State Registrar, 6 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED

JAN 3 1916

BUTLER COUNTY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll Co.

21506

64

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 71.Village or City Uniontown

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Hamilton Routson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan. 26, 1833
(Month) (Day) (Year)

7 AGE 82 yrs. 11 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS
10 NAME OF FATHER Henry Routson
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Mary Garner
13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Clyde Routson(Address) Buckeytown Ind.

15 Filed Dec 28th, 1915, Frank H. Billmeyer,
Local REGISTRAR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 25th, 1915 to Dec 27, 1915,
that I last saw him alive on Dec 26th, 1915

and that death occurred on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) yrs. mos. 4 ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Lucas Kemp, M. D.
Dec 27, 1915 (Address) Uniontown Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Methodist Cem. Uniontown Ind. DATE OF BURIAL Dec. 29, 1915.

20 UNDERTAKER C. C. Tress & Son ADDRESS Saneytown Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

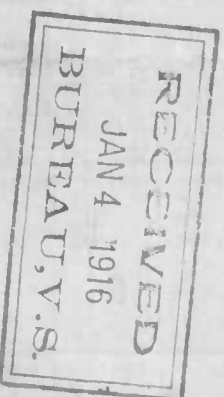
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21507STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 82Village or City Mt. Airy (No. 70) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Cora Wilson Sanner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH April 19th, 1881
(Month) (Day) (Year)

7 AGE 34 yrs. 8 mos. 11 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St. Mary's Leo. Md.

10 NAME OF FATHER Chas. Wesley Sanner

11 BIRTHPLACE OF FATHER (State or country) St. Mary's Leo. Md.

12 MAIDEN NAME OF MOTHER Annie O. Unkle

13 BIRTHPLACE OF MOTHER (State or country) Balto. City, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard E. Sanner(Address) Mt Airy Md.

15 Filed Dec 30, 1915 P. L. Pankles

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 30th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 10th, 1915, to Dec. 30th, 1915, that I last saw her alive on Thursday Dec. 30th, 1915, and that death occurred on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs. 9 mos. 3 ds.Contributory
Secondary

(Signed) J. Albert Rice (Duration) ____ yrs. ____ mos. ____ ds. M. D.
Dec. 30th, 1915 (Address) Mt. Airy, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Balto. City DATE OF BURIAL Jan 1, 1916
London Park Cem.

20 UNDERTAKER Bert Bouman ADDRESS Mt Airy Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Driver," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septæmiæ," "Prenatal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telæmæ*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 6 - 1916
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Canal 21508
 County Canal
 Village or City Sykesville (No. 154)
 Registration Dist. No. 74
 2 FULL NAME Mrs. Schleich

STATE OF MARYLAND
CERTIFICATE OF DEATH

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED OR DIVORCED unknown
 (Write the word)

6 DATE OF BIRTH unknown, 1 (Year)
 (Month) (Day)

7 AGE 48 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work unknown
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) unknown

PARENTS
 10 NAME OF FATHER "
 11 BIRTHPLACE OF FATHER (State or country) "
 12 M maiden NAME OF MOTHER "
 13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert D. Duman
 (Address) Sykesville, Md.

15 Filed Dec. 10, 1915 Robert D. Duman
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 9, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1915, to Dec 9, 1915, that I last saw him alive on Dec 9, 1915, and that death occurred on the date stated above, at 9 m. The CAUSE OF DEATH * was as follows:

Senile Extension
unknown
 (Duration) yrs. mos. ds.
 Contributory General Arteriosclerosis
 Secondary Nephritis
 (Duration) yrs. mos. ds.
 (Signed) Robert D. Duman, M. D.
12-9 - 1915 (Address) Sykesville, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the unknown State, yrs. mos. ds.
 Where was disease contracted, if not at place of death? unknown
 Former or usual residence Balto City

19 PLACE OF BURIAL OR REMOVAL Bethesda, Md. DATE OF BURIAL Dec. 14, 1915
 20 UNDERTAKER J. O. R. Shaw ADDRESS Sykesville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Collegical," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Heavier wound of hand—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If the certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JAN 3 1916
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Carroll</u>		21509/231		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Westminster</u> (No. <u>119</u>)		Registration Dist. No. <u>26</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Harry Wendall Shaeffer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widower</u> (Write the word)			
6 DATE OF BIRTH <u>May 26, 1862</u> (Month) (Day) (Year)					
7 AGE <u>53</u> yrs. <u>6</u> mos. <u>17</u> ds. OR <u>1</u> day. <u>10</u> hrs. <u>45</u> min. ? If LESS than 1 day, hrs. min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Cigar Maker</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS					
10 NAME OF FATHER <u>William H. Shaeffer</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>Sarah E. Quisler</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Shaeffer</u> (Address) <u>Westminster</u>					
15 FILED <u>Dec-14-1915</u> <u>W. S. Shrine</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Dec 13, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 4, 1915</u> to <u>Dec 13, 1915</u> that I last saw him alive on <u>Dec 13, 1915</u> and that death occurred on the date stated above, at <u>10:45 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Acute Peritonitis</u>					
Contributory <u>Uræmia</u> Secondary					
(Signed) <u>John J. Stewart</u> , M. D. <u>Dec 14, 1915</u> (Address) <u>Westminster Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>13</u> yrs. <u>6</u> mos. <u>17</u> ds. In the State <u>13</u> yrs. <u>6</u> mos. <u>17</u> ds. Where was disease contracted, if not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Westminster</u>				DATE OF BURIAL <u>Dec 16, 1915</u>	
20 UNDERTAKER <u>Frank C. Shaffer</u>				ADDRESS <u>Westminster</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

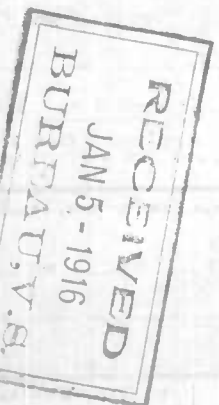
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

County Carroll 21510STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. _____

Village or City Hyers Dist (No. _____) St.; _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Alice Shely

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 12, 1879
(Month) (Day) (Year)

7 AGE 36 yrs. 8 mos. — ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Joseph Grimes

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Sally Shaffer

13 BIRTHPLACE OF MOTHER (State or country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Shely
(Address) Gettystown Pa

15 Filed Dec 16, 1915 John W. Hammett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 12, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1915, to Dec 12, 1915, that I last saw her alive on Dec 10, 1915.

and that death occurred on the date stated above, at 5:45 P. m, The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines (Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Pulmonary Tuberculosis (Duration) 1 1/2 yrs. ____ mos. ____ ds.
(Signed) G. Lewis Wetzel, M. D.
Dec 16, 1915. (Address) Union Mills Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Gettystown Penn DATE OF BURIAL Dec 16, 1915

20 UNDERTAKER John Halin Gettystown Pa ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

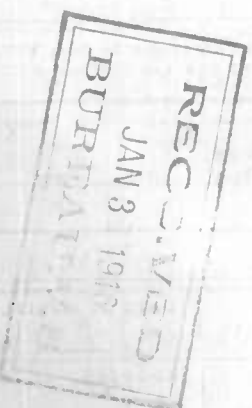
Approved by U. S. Census and American Public Health
Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

21511

(170)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (No. Springfield State Hospital Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary E. Slangenbaupt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 25, 1844
(Month) (Day) (Year)

7 AGE 71 yrs. 8 mos. 23 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Slangenbaupt

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Schoff

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) S. S. Hosp., Sykesville, Md.

15 Filed Dec. 17, 1915 Robert L. Quinn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 17, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1915, to Dec. 16, 1915,

that I last saw him alive on Dec. 16, 1915,

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH * was as follows:

Anterior Sclerosis & Chronic
Intestinal Obstruction (Duration) 2 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) John L. Wethered, M. D.

Dec. 17, 1915 (Address) S. S. Hosp., Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 11 mos. 18 ds. In the State, 71 yrs. 8 mos. 23 ds.

Where was disease contracted, If not at place of death? Carroll Co., Md.

Former or usual residence Carroll Co., Md.

19 PLACE OF BURIAL OR REMOVAL Panymtown Md DATE OF BURIAL Dec. 19, 1915

20 UNDERTAKER Geo R. Weer ADDRESS Asp. Res. Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Tricery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 3 1916

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21512STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 81Village or City Union Bridge (No. 64) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary S. Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH 4 28 - 1844
(Month) (Day) (Year)

7 AGE 71 7 7 It LESS than
yrs. mos. ds. 1 day. hrs.
OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Frederick Co., Md.

PARENTS
10 NAME OF FATHER Balser Fogle
11 BIRTHPLACE OF FATHER (State or country) Fred Co. Md.
12 MAIDEN NAME OF MOTHER Susan Stover
13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Kate Smith(Address) Union Bridge Md.

15 Filed 12/7, 1915 Leslie Rupp
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1915, to Dec 5, 1915,
that I last saw her alive on Dec 5, 1915,
and that death occurred on the date stated above, at 3:45 p.

The CAUSE OF DEATH was as follows:

Unilateral Paralysis
probably Stenocardia

Contributory Hypostatic Pneumonia
Secondary (Duration) yrs. mos. 6 ds.

(Signed) J. H. Legg, M. D.
Dec 6, 1915 (Address) Union Bridge Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Beaver Dam DATE OF BURIAL 12-8, 1915

20 UNDERTAKER Frank J. Shriver ADDRESS Union Bridge Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Cart engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County CarrollVillage or City Gaumber

(No.)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 28

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James W Spencer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

July 24, 1853
(Month) (Day) (Year)

7 AGE

62 yrs 4 mos 15 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

David Spencer

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (State or country)

Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E Spencer

(Address)

Gaumber

15

Filed Dec 11, 1915 E. L. Krimer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1915, to Dec 9, 1915.that I last saw him alive on Nov 8, 1915.and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Henry M. Fitch, M. D.Dec 10, 1915 (Address) Westminster Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Gaumber

DATE OF BURIAL

Dec 11, 1915

20 UNDERTAKER

Frank C Sharrer

ADDRESS

Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

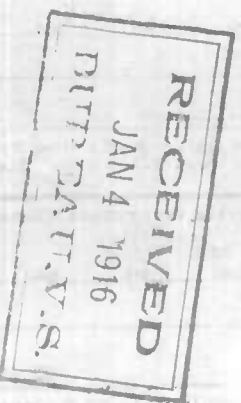
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll

21514

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 80Village or City New Windsor Md

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frank Steinberg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct 6, 1880
(Month) (Day) (Year)

7 AGE 75 yrs. 2 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS
10 NAME OF FATHER Fred Steinberg
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Edward Greenman(Address) New Windsor

15 Filed Dec 22, 1915 J. Edward Post
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 21st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1915, to December 21st, 1915, that I last saw him alive on December 20th, 1915, and that death occurred on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH was as follows:
Chronic Diffuse Nephritis

Contributory Arterio-Sclerosis
Secondary Unknown

(Signed) Stirling Dutton, M. D.
Dec 22, 1915 (Address) New Windsor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yr. mos. ds. In the State, yr. mos. ds.
Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL Dec 24, 1915

20 UNDERTAKER W. B. Banker & Son ADDRESS Westminster Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

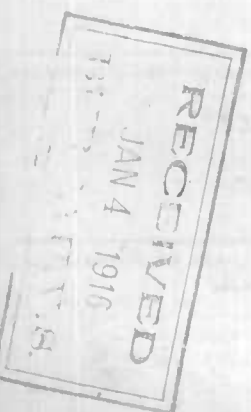
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Rail engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

21515

120

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Lykesville (No. Springfield Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles R. Stier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH February 19th 1915
(Month) (Day) (Year)

7 AGE 26 yrs. 10 mos. 4 ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Factory Worker
(b) General nature of industry business, or establishment in which employed (or employer) -

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER John Stier

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Donaldson

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Margaret Stier
(Address) 904 S. Carey St. Balto Md

15 Filed Dec 23, 1915 Robert J. Dwan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 23rd 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 26th 1915 to Dec 23rd 1915, that I last saw him alive on Dec 23rd 1915, and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis
over
(Duration) yrs. 10 mos. ds.

Contributory Chronic Valvular Heart Disease
Secondary over 10
(Duration) yrs. 10 mos. ds.
(Signed) John Norfolk Morris, M. D.
Dec. 23rd 1915 (Address) S.S. Hop. Lykesville Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 10 mos. 15 ds. In the State, 26 yrs. 10 mos. 4 ds.
Where was disease contracted, Balto. Md
If not at place of death?
Former or usual residence Balto. Md

19 PLACE OF BURIAL OR REMOVAL Balto City Md DATE OF BURIAL Dec 25 1915

20 UNDERTAKER Geo R. Weer ADDRESS Reflexion Md

If more blanks are needed, address State Registrar 16-W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Rocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 3 1916

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Carroll 21516
Village or City Sykesville (No. 64) St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74

[If death occurred in a hospital or institution give its NAME instead of street and number.]

2 FULL NAME Mrs Chaulatto Virginia Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH June 7th, 1844
(Month) (Day) (Year)

7 AGE 71 yrs. 6 mos. 7 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Howard Co. Md

10 NAME OF FATHER George R. Hayworth

11 BIRTHPLACE OF FATHER (State or country) Baltimore Co. Md

12 MAIDEN NAME OF MOTHER Rebecca Butler

13 BIRTHPLACE OF MOTHER (State or country) Howard County Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. E. Brown-Saunders

(Address) Sykesville Md.

15 Filed Dec. 15, 1915 Robert L. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1915, to Dec 14, 1915, that I last saw him alive on Dec 14, 1915, and that death occurred on the date stated above, at 12:30 pm.

The CAUSE OF DEATH * was as follows:

Capillary Cerebral
Stenorrhage

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Cerebral
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Samuel B. Sprueller, M. D.
Dec 14, 1915 (Address) Sykesville Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sykesville Md DATE OF BURIAL Dec. 16, 1915

20 UNDERTAKER Geo R Ween ADDRESS Sykesville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 3 1916
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

21517

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 72Village or City Bachmans Mill (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Jacob Washington Swenk

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Feb. 22, 1884
(Month) (Day) (Year)

7 AGE

31 yrs. 9 mos. 15 ds. OR LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Carroll Co., Md.

PARENTS

10 NAME OF FATHER

William Swenk

11 BIRTHPLACE OF FATHER (State or country)

Franklin Co. Pa.

12 MAIDEN NAME OF MOTHER

Susan Bachman

13 BIRTHPLACE OF MOTHER (State or country)

Adams Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Swenk(Address) Westminster Md.

15

Filed Dec. 8, 1915 John H. Humbert

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 7, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from I saw him for first time after death found dead on bed & I was called after that I last saw him alive on Between the hours of 12 P.M. & 3 A.M. and that death occurred on the date stated above, at 1915 m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Sherman, M. D.
Dec 7, 1915 (Address) Manchester Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bachmans Lenoxy Dec 10, 1915

20 UNDERTAKER

ADDRESS

Edw. F. Graft Union Mills Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

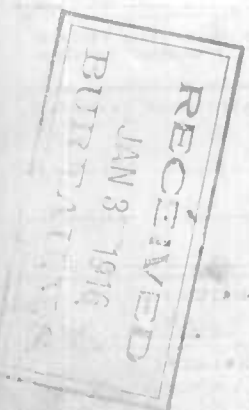
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll 21518

(100)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (No. Springfield Hospital St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Richard C. Thomas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single6 DATE OF BIRTH Unknown, 1871
(Month) (Day) (Year)7 AGE 44 yrs. - mos. ds. 11 LESS than 1 day, hrs. OR mo. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L. A. Thomas(Address) 723 Ramsey St Balto Md15 Filed Dec. 14, 1915 Robt D. Owen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 14th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from July 26th, 1915, to December 14th, 1915, that I last saw him alive on December 13th, 1915, and that death occurred on the date stated above, at 1:05 a. m.

The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis
unknown
(Duration) yrs. mos. ds.Contributory Chronic Valvular Heart -
Secondary Disease
(Duration) yrs. mos. ds. over 10 years(Signed) John Norfolk Morris, M. D.
Dec. 14th, 1915 (Address) 55 Hosp. Sykesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 10 yrs. 29 mos. 29 ds. In the State, 44 yrs. - mos. ds.Where was disease contracted, if not at place of death? -Former or usual residence Balto. City Md.19 PLACE OF BURIAL OR REMOVAL Balto City Md DATE OF BURIAL Dec 16th, 191520 UNDERTAKER Gas B. Weir ADDRESS Sykesville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Procery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, peritoneum, etc., Carcinoma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 31 1916

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Carroll 21519

Village or City New Windsor (No. _____) St.; _____ Ward)

2 FULL NAME Ray C. Utz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 6, 1914
(Month) (Day) (Year)

7 AGE 4 yrs. 3 mos. 26 ds. If LESS than 1 day, ____ hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll Co.

10 NAME OF FATHER Harry Utz

11 BIRTHPLACE OF FATHER (State or country) Carroll Co.

12 MAIDEN NAME OF MOTHER Ola Mae

13 BIRTHPLACE OF MOTHER (State or country) Carroll Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Utz

(Address) New Windsor

15 Filed Dec 3, 1915 J. Edgar and Mat
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 80

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th, 1915, to Dec 2, 1915,

that I last saw him alive on Dec 2, 1915,

and that death occurred on the date stated above, at 30 m.

The CAUSE OF DEATH * was as follows:
Intestinal Obstruction

Contributory Peritonitis
Secondary

(Signed) Dr E. Whitehill, M. D.
Dec 2, 1915 (Address) New Windsor Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bethel (Camolton) Dec 5, 1915

20 UNDERTAKER ADDRESS

H. Banker & Son Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (nearly synonymous), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21520STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville (No. Springfield State Hosp. St.; Hosp. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Van Horn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Unknown Unknown 1844
(Month) (Day) (Year)

7 AGE 71 yrs. None mos. None ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Virginia

10 NAME OF FATHER (Unknown) Underwood

11 BIRTHPLACE OF FATHER
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Henderson

13 BIRTHPLACE OF MOTHER
(State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) S.S. Hosp., Sykesville, Md.

15 Filed Dec 4, 1915 R. P. Linn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 3, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1915, to Dec. 3, 1915,

that I last saw him alive on Dec. 3, 1915,

and that death occurred on the date stated above, at 11:00 m.

The CAUSE OF DEATH * was as follows:

Arterio-Sclerosis & Chronic
Intestinal Myopathy (Duration) 1 yr. 4 mo. 25 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) John L. Withers, M. D.
Dec. 3, 1915 (Address) S.S. Hosp., Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 4 mos. 25 ds. In the Unknown State, 23 yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence Brownsville Co., Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fred City Md Dec 6, 1915

20 UNDERTAKER

ADDRESS

Geo T. Weer Sykesville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED
JAN 3 1916
BUREAU U. S.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

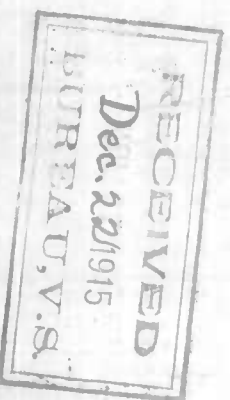
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County Carroll 21522STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 75Village or City Manchester Md. (No. 115), St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jacob Wink

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH

July 14, 1844
(Month) (Day) (Year)

7 AGE

71 yrs. 4 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Carpenter Undertaker

9 BIRTHPLACE

(State or country)

Carroll Co Md.

PARENTS

10 NAME OF FATHER

John Wink11 BIRTHPLACE OF FATHER
(State or country)Carroll Co. Md.

12 MOTHER NAME OF MOTHER

Margaret R Wilhelm13 BIRTHPLACE OF MOTHER
(State or country)Baltimore Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willie D. Hoffman

(Address)

Manchester Md

15

Filed 12/15, 1915J. O. Ballew

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 28, 1915, to Dec 13, 1915,that I last saw him alive on Dec 13, 1915,and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH * was as follows:

Jaundice

Contributory

Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) Jacob H. Suman, M. D.Dec 14, 1915 (Address) Manchester Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Manchester Md Dec 15, 1915

20 UNDERTAKER

ADDRESS

A. S. Marshall Baltimore Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

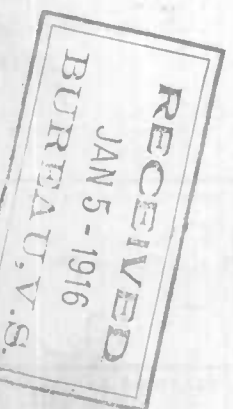
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Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or NONFATAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Cornwall</u> 21023 (S) 1329		Registered No. <u>76</u>	
Village or City <u>Westminster</u> (No. <u>1</u>)		St; <u>W</u> Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mr. James (Still) Burns</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	
6 DATE OF BIRTH <u>December - 8th, 1915</u> (Month) (Day) (Year)			
7 AGE <u>It LESS than 1 day, hrs. yrs. mos. ds. OR min. ?</u>			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Cornwall E. Ind</u>			
PARENTS	10 NAME OF FATHER <u>Raymond Wignert</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Cornwall E. Ind</u>		
	12 MAIDEN NAME OF MOTHER <u>Millie Frizzell</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Cornwall E. Ind</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raymond Wignert</u> (Address) <u>Westminster Ind</u>			
15 Filed <u>Dec 8th</u> , 1915 <u>E. W. Shreier</u> REGISTRAR			
16 DATE OF DEATH <u>December 8</u> , 1915 (Month) (Day) (Year)			
17 I HEREBY CERTIFY. That I attended deceased from <u>191</u> to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred on the date stated above, at <u>m</u> , The CAUSE OF DEATH* was as follows: <u>Still Burn</u> (Duration) <u> yrs. mos. ds.</u>			
Contributory (Secondary) <u>(Duration) yrs. mos. ds.</u>			
(Signed) <u>John J. Stewart</u> , M. D. <u>Dec 8th</u> , 1915 (Address) <u>Westminster Ind</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> yrs. mos. ds.</u> in the State <u> yrs. mos. ds.</u> Where was disease contracted, If not at place of death? Former or usual residence <u>At Home Westminster Ind</u>			
19 PLACE OF BURIAL OR REMOVAL <u>At Home Westminster Ind</u>		DATE OF BURIAL <u>Dec 8</u> , 1915	
20 UNDERTAKER <u>Raymond Wignert</u>		ADDRESS <u>Westminster Ind</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

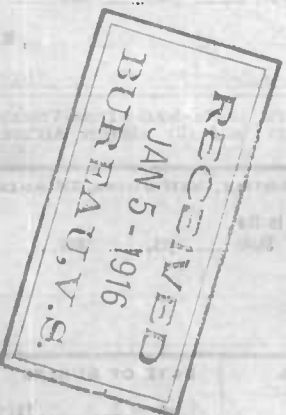
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal, septicæmia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll 21524Village or City Hampstead (No. _____, _____, _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 77

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry Wilson Wisner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 9 / 6 / 1914
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 17 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Harry Willard Wisner

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Rosina Wisner

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15 Filed Dec 24, 1915 Immar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 / 23 / 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1915 to Dec 23, 1915

that I last saw him alive on Dec 23, 1915

and that death occurred on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheritic Group.
(Duration) — yrs. — mos. 4 ds.

Contributory _____
Secondary _____

(Duration) — yrs. — mos. — ds.
(Signed) Edgar M. Bush, M. D.
12/24/1915 (Address) Hampstead Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Hampstead Md DATE OF BURIAL 12-24, 1915

20 UNDERTAKER J. V. Tipton & Son ADDRESS Hampstead Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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